November 8, 2019

By EMAIL (OMH.Parity@omh.ny.gov)

Commissioner Anne Marie T. Sullivan, M.D.
Office of Mental Health
44 Holland Avenue
Albany, NY 12229

RE: Guiding Principles for the Review and Approval of
Clinical Review Criteria for Mental Health Services

Dear Commissioner Sullivan:

The Kennedy Forum, American Association for Community Psychiatry, New York State Psychiatric Association, National Association for Behavioral Health Care, American Foundation for Suicide Prevention, and the Committee on Psychotherapy of the Group for the Advancement of Psychiatry write in response to the Office for Mental Health's solicitation of public comments regarding the guiding principles that OMH intends to use to assess the adequacy of insurers' clinical review criteria for the treatment of mental health conditions.

Having reviewed the Guiding Principles for the Review and Approval of Clinical Review Criteria for Mental Health Services ("Principles") issued on October 25, 2019 by OMH, we believe that the Principles have the potential to enhance access to meaningful mental health care in the State of New York. We provide the following comments to ensure that inconsistencies within the Principles, as currently drafted, are addressed by OMH.

1. The Principles should reference "intermediate services" in addition to "acute care" and replace "acute care continuum" with "level of service intensity continuum."

Although the Principles, in paragraph 4, specifically enumerate (and therefore implicitly differentiate) "acute care services, residential services for children, or intensive outpatient

services," the Principles, in paragraph 2, only reference "utilization review of ***acute*** care" while omitting reference to "intermediate services," defined by the Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") to include "services that fall between inpatient care for acute conditions and regular outpatient care."[1] Similarly, the Principles, in paragraph 7, reference "criteria for ***acute*** services" while omitting reference to "intermediate services," and thereafter refer to "the ***acute*** care continuum in NYS map[ping] well onto the levels of care defined by LOCUS and CALOCUS." By omitting reference to "intermediate services" while referencing an "acute care continuum" instead of a "level of service intensity continuum," the Principles suggest that intermediate services, including residential treatment and intensive outpatient treatment, are necessarily "acute," a proposition that has been not only rejected by federal courts,[2] but one which is expressly inconsistent with the level of care placement tools published by the American Association of Community Psychiatrists. For example, the LOCUS indicates that, with respect to residential treatment, "[l]onger-term care for persons with chronic, non-recoverable disability . . . may be included at this level"[3] and identifies three sub-levels of care, including "Level 5B: Moderate Intensity Intermediate Stay Residential Treatment Programs" and "Level 5C: Moderate Intensity Long Term Residential Treatment Programs."[4] According to LOCUS, Level 5C programs "provide intensive treatment as described for all Level 5 programs and the length of stay will vary from two months to a year."

While we acknowledge that acuity must be considered at all levels of service intensity, we are equally mindful that insurers have come to rely on acuity as the primary, if not sole, determinant of coverage at all levels of service intensity. The results have been tragic, particularly for individuals with chronic and severe mental illnesses whose care is all too often shifted to publicly-funded programs.[5] As explained by the *Wit* court, generally accepted standards of patient placement and service intensity selection simply do not limit the duration of treatment to "acute services"—particularly at the outpatient, intensive outpatient, and residential levels of care.

Though the Principles, in paragraph 6, appropriately acknowledge that "[t]he State will not approve clinical review criteria which only take into consideration current symptoms and current level of risk in determining the appropriate level of care," for the reasons described above, we believe that the Principles should expressly distinguish intermediate care from acute services and refer to a "level of service intensity continuum."

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[1] 78 Fed. Reg. 68240, 68259-62 (Nov. 13, 2013).

[2] *See*, for example, *Wit v. United Behavioral Health,* No. 14-CV-02346-JCS, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019) (rejecting UBH's residential treatment guidelines due to systemic acuity defects) and *Charles W. v. Regence BlueCross BlueShield of Oregon*, No. 2:17-CV-00824-TC, 2019 WL 4736932, (D. Utah Sept. 27, 2019) (reversing residential treatment coverage denial due to insurer's reliance on MCG guideline for ***acute*** residential treatment).

[3] LOCUS Instrument 20, V. LEVEL FIVE - Medically Monitored Residential Services, page 28.

[4] LOCUS Instrument 20, Appendix I: LOCUS Supplementary Criteria for Residential Placement, pages 36-37.

[5] https://www.cbsnews.com/news/mental-health-insurance-coverage-families-fight-for-life-saving-care/

2. <u>The Principles should reference residential mental health treatment for adults – not just for children.</u>

The Principles, in paragraph 4, indicate that "[t]he State will not approve a UR Agent's criteria for acute care services, residential services ***for children***, or intensive outpatient services if they contain separate standards for admission, continued stay, and discharge of patients," suggesting that the State will either not review any criteria for adult residential treatment or that criteria for adult residential treatment may contain separate standards for admission, continued stay, and discharge. Similarly, the Principles, in paragraph 7, omit reference to "Medically Monitored Residential Services" with respect to residential treatment of adults. Because all insurance policies must provide residential treatment benefits for ***all*** insureds, we believe that paragraphs 4 and 7 in the Principles should be supplemented with references to adults.[6]

Subject to the above modifications, we believe that the Principles should enhance patient access to meaningful mental health care and provide insurers with adequate notice regarding the review and approval of clinical review criteria for mental health services.

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[6] New York Mental Hygiene Law § 1.03(33) specifically references "residential care center for adults" as "a facility which provides long term residential care and support services to mentally ill adults, provides case management and medication management services, and assists residents in securing clinical, vocational and social services necessary to enable the resident to continue to live in the community." Even if this statute did not specifically reference residential mental health treatment for adults, MHPAEA and Timothy's Law would nonetheless obligate insurers to cover such care—particularly since insurers cover subacute medical services, such as treatment at skilled nursing facilities. *See* 45 C.F.R. § 146.136(c)(4)(iii):

Example 9.
Facts. A plan generally covers medically appropriate treatments. The plan automatically excludes coverage for inpatient substance use disorder treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For inpatient treatment outside of a hospital for other conditions (including freestanding or residential treatment centers prescribed for mental health conditions, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the inpatient treatment is medically appropriate for the individual, based on clinically appropriate standards of care.

Conclusion. In this *Example 9,* the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation - medical appropriateness - is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of substance use disorder treatment in any setting outside of a hospital is not comparable to the conditional exclusion of inpatient treatment outside of a hospital for other conditions.

Example 10.
Facts. A plan generally provides coverage for medically appropriate medical/surgical benefits as well as mental health and substance use disorder benefits. The plan excludes coverage for inpatient, out-of-network treatment of chemical dependency when obtained outside of the State where the policy is written. There is no similar exclusion for medical/surgical benefits within the same classification.

Conclusion. In this Example 10, the plan violates the rules of this paragraph (c)(4). The plan is imposing a nonquantitative treatment limitation that restricts benefits based on geographic location. Because there is no comparable exclusion that applies to medical/surgical benefits, this exclusion may not be applied to mental health or substance use disorder benefits.

Sincerely,

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